# HEALTH SYSTEM REFORM - INSURANCE MARKET

2009 GENERAL SESSION

STATE OF UTAH

**LONG TITLE**

**General Description:**

This bill amends the Insurance Code to expand access to the health insurance market, stabilize premiums, and create insurance market flexibility.

**Highlighted Provisions:**

This bill:

- beginning January 1, 2010, gives a sole proprietor who meets certain requirements access to the guaranteed issue and pre-existing condition protections in the small group market;
- establishes requirements for insurer transparency of plan benefits and offerings;
- gives the insurance commissioner rule making authority to adopt standards for the electronic submission of health plan information to the Internet portal;
- establishes a new basic benefit package called the Utah NetCare Basic Health Care Plan which includes:
  - a low and high deductible plan;
  - first dollar coverage for certain benefits; and
  - lower premiums;
- amends the exemptions from health insurance standards to facilitate a mandate-free, low-cost product;
- authorizes a preferred provider organization and a health maintenance organization to offer a new health benefit plan that does not include certain state mandated benefits;
- authorizes an employer to offer the Utah NetCare Basic Health Care Plan as alternative coverage for state mini-COBRA coverage, federal COBRA coverage, and a conversion plan;
- requires health insurance producers to disclose payment of commissions to a

customer prior to the customer's purchase or renewal of a health benefit plan;

- establishes a defined contribution arrangement which:
  - requires an insurer to offer products through the Internet portal and through a defined contribution arrangement before an insurer may offer products that are not subject to state mandates;
  - permits small employers, large employers, and ERISA plans to participate;
  - requires employers who wish to participate to establish Section 125 plans that allow pre-tax dollars for premium payments;
  - gives the employees of a participating employer the option to choose either a plan from the Internet portal, a plan selected by the employer, or no coverage;
  - prohibits an insurer from establishing, as a condition for coverage, an employer minimum contribution level;
  - permits an insurer to require minimum participation of eligible employees as a condition of coverage;
  - requires the insurer to accept premium payments from multiple sources, including government assistance and contributions from other employers;
  - permits underwriting in the defined contribution arrangements based only on age, geography and family composition; and
  - requires insurers offering products through defined contribution arrangements to participate in a risk adjustment mechanism; and
- establishes the Utah Health Re-Insurance Pool as a risk adjuster mechanism for defined contribution arrangements which includes:
  - creating the pool as a non-profit entity within the Department of Insurance;
  - establishing a governing board for the pool;
  - requiring the board to adopt a plan of operation;
  - establishing powers of the board;
  - establishing oversight powers for the insurance commissioner;
  - requiring the board to select a pool administrator;
  - establishing eligibility for pool membership and ceding risk to the pool;
  - authorizing assessments for the pool; and
  - creating the Utah Health Re-Insurance Pool Enterprise Fund.

**Monies Appropriated in this Bill:**

None

**Other Special Clauses:**

None

**Utah Code Sections Affected:**

AMENDS:

**31A-1-301**, as last amended by Laws of Utah 2008, Chapters 345 and 382

**31A-8-501**, as last amended by Laws of Utah 2004, Chapters 90, 229, and 367

**31A-22-613.5**, as last amended by Laws of Utah 2008, Chapters 241 and 345

**31A-22-614.5**, as last amended by Laws of Utah 2008, Chapters 379 and 382

**31A-22-633**, as last amended by Laws of Utah 2005, Chapter 123

**31A-22-722**, as last amended by Laws of Utah 2006, Chapter 188

**31A-22-723**, as last amended by Laws of Utah 2008, Chapters 241 and 250

**31A-23a-401**, as last amended by Laws of Utah 2007, Chapter 307

**31A-23a-501**, as renumbered and amended by Laws of Utah 2003, Chapter 298

**31A-30-102**, as last amended by Laws of Utah 2008, Chapter 345

**31A-30-103**, as last amended by Laws of Utah 2007, Chapter 307

**31A-30-107**, as last amended by Laws of Utah 2004, Chapter 329

**31A-30-112**, as last amended by Laws of Utah 2008, Chapter 345

ENACTS:

**31A-22-618.5**, Utah Code Annotated 1953

**31A-22-724**, Utah Code Annotated 1953

**31A-30-201**, Utah Code Annotated 1953

**31A-30-202**, Utah Code Annotated 1953

**31A-30-203**, Utah Code Annotated 1953

**31A-30-204**, Utah Code Annotated 1953

**31A-42-101**, Utah Code Annotated 1953

**31A-42-102**, Utah Code Annotated 1953

**31A-42-103**, Utah Code Annotated 1953

**31A-42-201**, Utah Code Annotated 1953

**31A-42-202**, Utah Code Annotated 1953

**31A-42-203**, Utah Code Annotated 1953

**31A-42-204**, Utah Code Annotated 1953

**31A-42-205**, Utah Code Annotated 1953

**31A-42-206**, Utah Code Annotated 1953

**31A-42-207**, Utah Code Annotated 1953

**31A-42-208**, Utah Code Annotated 1953

**31A-42-209**, Utah Code Annotated 1953

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*Be it enacted by the Legislature of the state of Utah:*

Section 1. Section **31A-1-301** is amended to read:

**31A-1-301. Definitions.**

As used in this title, unless otherwise specified:

(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from:

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

(c) "Accident and health insurance" does not include workers' compensation insurance.

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection (159).

(4) "Adult" means a natural person who has attained the age of at least 18 years.

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of natural persons manages the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which a natural person does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301.

(7) "Alien insurer" means an insurer domiciled outside the United States.

(8) "Amendment" means an endorsement to an insurance policy or certificate.

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more natural persons if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of human life.

(10) "Application" means a document:

(a) (i) completed by an applicant to provide information about the risk to be insured; and

(ii) that contains information that is used by the insurer to evaluate risk and decide whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

(II) a modification of the coverage as originally offered; or

(B) decline to insure the risk; or

(b) used by the insurer to gather information from the applicant before issuance of an annuity contract.

(11) "Articles" or "articles of incorporation" means:

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition with or without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(17) "Business of insurance" is defined in Subsection (85).

(18) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

(19) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.

(b) "Bylaws" includes comparable rules for a trust or other entity that is not a corporation.

(20) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and an affiliated company; or

(b) in the case of a group or association, an insurer:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(21) "Casualty insurance" means liability insurance as defined in Subsection (97).

(22) "Certificate" means evidence of insurance given to:

(a) an insured under a group insurance policy; or

(b) a third party.

(23) "Certificate of authority" is included within the term "license."

(24) "Claim," unless the context otherwise requires, means a request or demand on an

insurer for payment of a benefit according to the terms of an insurance policy.

(25) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

(26) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection (26)(a) apply to the equivalent supervisory official of another jurisdiction.

(27) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in Subsection (27)(a)(i) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (27)(a)(ii).

(28) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (28)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have

control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

(29) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(30) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(31) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(32) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.

(b) "Stock corporation" means a stock insurance corporation.

(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

(33) "Creditable coverage" has the same meaning as provided in federal regulations

adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

(34) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

(35) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

(36) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

(37) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

(38) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(39) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer or consultant employer.

(41) "Deadline" means the final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

(42) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

(43) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

(44) "Department" means the Insurance Department.

(45) "Director" means a member of the board of directors of a corporation.

(46) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) any occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(47) "Disability income insurance" is defined in Subsection (76).

(48) "Domestic insurer" means an insurer organized under the laws of this state.

(49) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

(50) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (50)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (50)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(51) "Employee" means an individual employed by an employer.

(52) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(53) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax revenues.

(54) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

(55) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

(56) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

(57) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

(58) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(59) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(60) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

(61) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

(62) (a) "Filed" means that a filing is:

(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in applicable statute, rule, or filing order; and

(iii) accompanied by the appropriate fee in accordance with:

(A) Section 31A-3-103; or

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (62)(a).

(63) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement; or

(o) an outline of coverage.

(64) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

(65) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

(66) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

(b) "Form" does not include a document specially prepared for use in an individual case.

(67) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

(68) "General lines of authority" include:

(a) the general lines of insurance in Subsection (69);

(b) title insurance under one of the following sublines of authority:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative;

(iii) search and escrow, including authority to act as a title marketing representative; and

(iv) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(69) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

(70) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(71) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

(B) an agreement that is collateral to the policy.

(b) A group insurance policy may include a member of the policyholder's family or a dependent.

(72) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

(73) (a) Except as provided in Subsection (73)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

(74) "Health care" means any of the following intended for use in the diagnosis,

treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

(75) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

(76) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

(77) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(78) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

(79) "Independently procured insurance" means insurance procured under Section

31A-15-104.

(80) "Individual" means a natural person.

(81) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

(82) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as the debts and obligations mature;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or

(c) an insurer is determined to be hazardous under this title.

(83) (a) "Insurance" means:

(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

(i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

(ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

(iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

(84) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(85) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection (75), by an organization that is or should be licensed under this title;

(b) providing a benefit to an employee in the event of a contingency not within the control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

(i) by a single employer or by multiple employer groups; or

(ii) through one or more trusts, associations, or other entities;

(c) providing an annuity:

(i) including an annuity issued in return for a gift; and

(ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (113);

(e) providing another person with insurance as defined in Subsection (83);

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, a contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including:

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

(v) transacting matters subsequent to the execution of the contract and arising out of the contract, including reinsurance; and

(h) doing, or proposing to do, any business in substance equivalent to Subsections (85)(a) through (g) in a manner designed to evade the provisions of this title.

(86) "Insurance consultant" or "consultant" means a person who:

(a) advises another person about insurance needs and coverages;

(b) is compensated by the person advised on a basis not directly related to the insurance placed; and

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

(87) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

(88) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

(i) "producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating a product of that insurer; and

(ii) "producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating a product of that insurer to an insurance customer or insured.

(89) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (89)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(90) (a) (i) "Insurer" means a person doing an insurance business as a principal including:

(A) a fraternal benefit society;

(B) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(C) a motor club;

(D) an employee welfare plan; and

(E) a person purporting or intending to do an insurance business as a principal on that person's own account.

(ii) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

(b) "Admitted insurer" is defined in Subsection (163)(b).

(c) "Alien insurer" is defined in Subsection (7).

(d) "Authorized insurer" is defined in Subsection (163)(b).

(e) "Domestic insurer" is defined in Subsection (48).

(f) "Foreign insurer" is defined in Subsection (65).

(g) "Nonadmitted insurer" is defined in Subsection (163)(a).

(h) "Unauthorized insurer" is defined in Subsection (163)(a).

(91) "Interinsurance exchange" is defined in Subsection (142).

(92) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(93) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(94) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

(95) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(b) through special enrollment.

(96) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

(b) "Legal expense insurance" includes an arrangement that creates a reasonable expectation of an enforceable right.

(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverage.

(97) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of a human being, or for damage to property, exclusive of the coverages under:

(A) Subsection (107) for medical malpractice insurance;

(B) Subsection (134) for professional liability insurance; and

(C) Subsection (168) for workers' compensation insurance;

(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of a human being, exclusive of the coverages under:

(A) Subsection (107) for medical malpractice insurance;

(B) Subsection (134) for professional liability insurance; and

(C) Subsection (168) for workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to property caused by:

(A) the breakage or leakage of a sprinkler, water pipe, or water container; or

(B) water entering through a leak or opening in a building; or

(v) for other loss or damage properly the subject of insurance not within another kind of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection (165);

(ii) residential dwelling liability insurance as defined in Subsection (145); and

(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.

(98) (a) "License" means the authorization issued by the commissioner to engage in an

activity that is part of or related to the insurance business.

(b) "License" includes a certificate of authority issued to an insurer.

(99) (a) "Life insurance" means:

(i) insurance on a human life; and

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

(iv) granting an additional benefit in the event of death by accident;

(v) granting an additional benefit to safeguard the policy against lapse; and

(vi) providing an optional method of settlement of proceeds.

(100) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

(101) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) another form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

(102) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through

a master, corporate, group, or individual policy.

(103) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance; and

(g) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

(104) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection (103); and

(b) a customer service representative.

(105) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

(106) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

(iii) for one or more necessary or medically necessary services that are:

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

(C) (I) a nonprofit health hospital; and

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (106)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(107) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(108) "Member" means a person having membership rights in an insurance corporation.

(109) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(110) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

(111) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

(112) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

(113) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time one or more:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (113)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

(114) "Mutual" means a mutual insurance corporation.

(115) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(116) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

(117) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

(118) "Order" means an order of the commissioner.

(119) "Outline of coverage" means a summary that explains an accident and health insurance policy.

(120) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

(121) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage; or

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

(122) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

(j) another similar entity or combination of entities acting in concert.

(123) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(124) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(125) "Plan year" means:

(a) the year that is designated as the plan year in:

(i) the plan document of a group health plan; or

(ii) a summary plan description of a group health plan;

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

(i) the year used to determine deductibles or limits;

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection (125)(a) or (b), the calendar year.

(126) (a) "Policy" means a document, including any attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

(b) "Policy" includes a service contract issued by:

(i) a motor club under Chapter 11, Motor Clubs;

(ii) a service contract provided under Chapter 6a, Service Contracts; and

(iii) a corporation licensed under:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or

(ii) a document that does not purport to have legal effect.

(127) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

(128) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

(129) "Policy summary" means a synopsis describing the elements of a life insurance policy.

(130) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

(131) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.

(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.

(132) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

(133) "Proceeding" includes an action or special statutory proceeding.

(134) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

(135) (a) Except as provided in Subsection (135)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance as defined in Subsection (81); and

(ii) ocean marine insurance as defined under Subsection (117).

(136) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

(b) the portion of a life insurance contract that provides long-term care insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

(ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue Code.

(137) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by a United States federal or state authority having regulatory authority over a bank or trust company; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of a financial institution whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

(138) (a) "Rate" means:

(i) the cost of a given unit of insurance; or

(ii) for property-casualty insurance, that cost of insurance per exposure unit either expressed as:

(A) a single number; or

(B) a pure premium rate, adjusted before the application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

(b) "Rate" does not include a minimum premium.

(139) (a) Except as provided in Subsection (139)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

(i) collecting, compiling, and furnishing loss or expense statistics;

(ii) recommending, making, or filing rates or supplementary rate information; or

(iii) advising about rate questions, except as an attorney giving legal advice.

(b) "Rate service organization" does not mean:

(i) an employee of an insurer;

(ii) a single insurer or group of insurers under common control;

(iii) a joint underwriting group; or

(iv) a natural person serving as an actuarial or legal consultant.

(140) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

(141) "Received by the department" means:

(a) except as provided in Subsection (141)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person; or

(ii) electronically; and

(b) if delivered to the department by a delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:

(i) statute;

(ii) rule; or

(iii) a specific filing order.

(142) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of the persons; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

(143) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

(144) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

(145) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

(146) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a liability assumed under a reinsurance contract.

(147) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

(148) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in a profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in

Subsections (148)(a)(i) through (xiv); or

(xvi) another interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) endowment policy; or

(C) annuity contract; or

(ii) a burial certificate or burial contract.

(149) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

(150) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection (150), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk which is related to the relationship or employment.

(c) "Self-insurance" does not include an arrangement with an independent contractor.

(151) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

(152) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

(153) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

(154) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) (i) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

[~~(b)~~] (ii) employs at least two employees on the first day of the plan year[~~.~~]; or

(b) beginning January 1, 2010, is an individual who:

(i) has a license to conduct business in the state; and

(ii) (A) if the individual operated the business during the previous taxable year, can demonstrate that for the previous taxable year, at least 50% of the adjusted gross income, as defined in Section 59-10-103, for the individual's total household came from the business for which the individual has a license; or

(B) if the individual did not operate the business during the previous taxable year, can demonstrate on the first day of the plan year, that at least 50% of the adjusted gross income, as defined in Section 59-10-103, for the individual's total household comes from the business for which the individual has a license.

(155) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

(156) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

(b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares are owned by that person either alone or with its affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

(157) Subject to Subsection (83)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from the failure of a principal to pay or perform the principal's obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

(158) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that is designated by the insurer as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that mutuals doing business in this state maintain specified minimum levels of permanent surplus.

(iii) Except for assessable mutuals, the minimum permanent surplus requirement is essentially the same as the minimum required capital requirement that applies to stock insurers.

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and casualty insurer as defined in Section 31A-17-601, the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection (161), that exceeds the product of:

(I) 2.5; and

(II) the sum of the insurer's or health organization's minimum capital or permanent surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection (161), that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

(ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

(159) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

(i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for which the insurer holds a license in this state; or

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt.

(160) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

(161) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

(162) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

(163) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"

means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

(164) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(165) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection (135).

(166) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

(167) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

(168) "Workers' compensation insurance" means:

(a) insurance for indemnification of an employer against liability for compensation based on:

(i) a compensable accidental injury; and

(ii) occupational disease disability;

(b) employer's liability insurance incidental to workers' compensation insurance and written in connection with workers' compensation insurance; and

(c) insurance assuring to a person entitled to workers' compensation benefits the compensation provided by law.

Section 2. Section **31A-8-501** is amended to read:

**31A-8-501. Access to health care providers.**

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility

licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a health maintenance organization contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; and

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located and:

(A) the board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member who has not contracted with a health maintenance organization to provide health care services to enrollees of the organization.

(2) Except for a health maintenance organization which is under the common ownership or control of an entity with a hospital located within ten paved road miles of an independent hospital, a health maintenance organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an

independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(3) A health maintenance organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center; or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the health maintenance organization contract.

(4) (a) A health maintenance organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as it pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A health maintenance organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the health maintenance organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A non-contracting independent hospital may not balance bill a patient when the health maintenance organization reimburses a non-contracting independent hospital or an

enrollee in accordance with Subsection (4)(a).

(b) A non-contracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

[~~(5)~~] (6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's health maintenance organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

[~~(6)~~] (7) Notwithstanding this section, a health maintenance organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

[~~(7)~~] (8) (a) A health maintenance organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection [~~(7)~~] (8)(d) by placing the notice in any health maintenance organization's provider list that is supplied to enrollees, including any website maintained by the health maintenance organization;

(ii) failing to provide notice of an enrolles's rights under this section when:

(A) an enrollee makes personal contact with the health maintenance organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about his rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the health maintenance organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A health maintenance organization shall:

(A) use the information developed by the commissioner under Subsection [~~(7)~~] (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the health maintenance organization's service area; and

(B) include the providers identified under Subsection [~~(7)~~] (8)(d)(i)(A) in the notice required in Subsection [~~(7)~~] (8)(d)(ii).

(ii) The health maintenance organization shall provide the following notice, in bold type, to enrollees as specified under Subsection [~~(7)~~] (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following non-HMO contracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to your HMO contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a [~~noncontracted~~] non-contracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your health maintenance organization at _____. If the HMO does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as

provided in Section 31A-2-216.

Section 3. Section **31A-22-613.5** is amended to read:

**31A-22-613.5. Price and value comparisons of health insurance -- Basic Health Care Plan.**

(1) (a) Except as provided in Subsection (1)(b), this section applies to:

(i) all health [~~insurance policies and~~] benefit plans;

(ii) all health maintenance organization contracts[~~.~~]; and

[~~(b) Subsection (3) applies to:~~]

[~~(i) all health insurance policies and health maintenance organization contracts; and~~]

(iii) coverage offered to state employees under Subsection 49-20-202(1)(a).

[~~(ii)~~] (b) Subsections (2)(b) does not apply to coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) [~~The~~] (a) By July 1, 2009, the commissioner shall adopt a Utah NetCare Basic Health Care Plan consistent with [~~this section to be offered~~] Subsection (5).

(b) (i) An insurer shall offer the Basic Health Care Plan described in Subsection (4) through December 31, 2009 under the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(ii) Beginning January 1, 2010, an insurer shall offer the Utah NetCare Basic Health Care Plan adopted under Subsection (2), under the open enrollment provisions of Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(c) Beginning January 1, 2010, an insurer shall offer the Utah NetCare Basic Health Care Plan developed under Subsection (2) as alternative coverage under Sections 31A-22-723 and 31A-22-724.

(3) (a) The commissioner shall promote informed consumer behavior and responsible health insurance and health plans by requiring an insurer [~~issuing health insurance policies or health maintenance organization contracts~~] subject to this section to provide to all enrollees, prior to enrollment in the health benefit plan or health insurance policy, [~~written~~] disclosure of:

(i) the plan designs and options offered by the insurer;

(ii) provider networks available under the insurer's plan designs;

(iii) wellness programs and incentives available under the insurer's plans;

[~~(i)~~] (iv) restrictions or limitations on prescription drugs and biologics including the

use of a formulary and generic substitution;

[~~(ii)~~] (v) coverage limits under the plan designs offered by the insurer; [~~and~~]

[~~(iii)~~] (vi) any limitation or exclusion of coverage including:

(A) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and

(B) beginning July 1, 2009, easily understood examples of a limitation or exclusion of coverage for a secondary medical condition[~~.~~], including any limitation from coverage for a secondary medical condition resulting from the use of an excluded drug;

[~~(b) In addition to the requirements of Subsections (3)(a), (d), and (e) an insurer described in Subsection (3)(a) shall file the written disclosure required by this Subsection (3) to the commissioner:~~]

(vii) for each plan design offered by the insurer:

(A) the percentage of claims paid by the insurer within 30 days of the date a claim is submitted to the insurer; and

(B) the percentage of adverse benefit determinations by the insurer which were subsequently overturned on independent review under Section 31A-22-629 as a percentage of total claims paid by the insurer; and

(viii) the department's rating of the insurer's solvency based on methodology established by the department by administrative rule.

(b) The commissioner shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act , and Section 31A-22-614.5, to implement standards for the electronic submission of the information required by this section. The administrative rules may require that the information be transmitted by the insurer to the department:

(i) upon commencement of operations in the state; and

(ii) anytime the insurer amends [~~any of the following~~] the items described in Subsection (3)(a)[~~:~~].

[~~(A) treatment policies;~~]

[~~(B) practice standards;~~]

[~~(C) restrictions;~~]

[~~(D) coverage limits of the insurer's health benefit plan or health insurance policy; or~~]

[~~(E) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.~~]

[~~(c) The commissioner may adopt rules to implement the disclosure requirements of this Subsection (3), taking into account:~~]

[~~(i) business confidentiality of the insurer;~~]

[~~(ii) definitions of terms;~~]

[~~(iii) the method of disclosure to enrollees; and~~]

[~~(iv) limitations and exclusions.~~]

[~~(d) If under Subsection (3)(a)(i) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:~~]

[~~(i) the drugs included;~~]

[~~(ii) the patented drugs not included;~~]

[~~(iii) any conditions that exist as a precedent to coverage; and~~]

[~~(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.~~]

[~~(e) Before December 1, 2008, insurers subject to this Subsection (3) shall report to the Legislature's Health and Human Services Interim Committee and Business and Labor Interim Committee, either collectively or independently regarding insurer efforts to inform enrollees of any limitation of coverage or exclusion for a secondary medical condition when an enrollee, or someone on the enrollee's behalf, contacts the insurer for pre-authorization of a procedure or use of a drug that is excluded or limited from coverage.~~]

[~~(f) (i)~~] (c) The department shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (3)(a)[~~(iii). (ii) Examples~~]. The examples of a limitation or exclusion of coverage provided [~~under Subsection (3)(a)(iii) or otherwise~~] are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(4) The Basic Health Care Plan [~~adopted by the commissioner under this section~~] an insurer must offer under the provisions of Subsection (2)(b)(i) shall provide for:

(a) a lifetime maximum benefit per person not to exceed $1,000,000;

(b) an annual maximum benefit per person not less than $250,000;

(c) an out-of-pocket maximum of cost-sharing features:

(i) including:

(A) a deductible;

(B) a copayment; and

(C) coinsurance;

(ii) not to exceed $5,000 per person; and

(iii) for family coverage, not to exceed three times the per person out-of-pocket maximum provided in Subsection (4)(c)(ii);

(d) in relation to its cost-sharing features:

(i) a deductible of:

(A) not less than $1,500 per person for major medical expenses; and

(B) for family coverage, not to exceed three times the per person deductible for major medical expenses under Subsection (4)(d)(i)(A); and

(ii) (A) a copayment of not less than:

(I) $25 per visit for office services; and

(II) $150 per visit to an emergency room; or

(B) coinsurance of not less than:

(I) 20% per visit for office services; and

(II) 20% per visit for an emergency room; and

(e) in relation to cost-sharing features for prescription drugs:

(i) (A) a deductible not to exceed $1,000 per person; and

(B) for family coverage, not to exceed three times the per person deductible provided in Subsection (4)(e)(i)(A); and

(ii) (A) a copayment of not less than:

(I) the lesser of the cost of the prescription drug or $15 for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or $25 for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or $35 for the highest level of cost for prescription drugs; or

(B) coinsurance of not less than:

(I) the lesser of the cost of the prescription drug or 25% for the lowest level of cost for prescription drugs;

(II) the lesser of the cost of the prescription drug or 40% for the second level of cost for prescription drugs; and

(III) the lesser of the cost of the prescription drug or 60% for the highest level of cost for prescription drugs.

(5) (a) The Utah NetCare Basic Health Care Plans required by Subsection (2)(a) shall be adopted by the commissioner by administrative rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act by July 1, 2009, and shall provide:

(i) healthy lifestyle and wellness incentives; and

(ii) the benefits described in this Subsection (5) or the actuarial equivalent of the benefits described in this Subsection (5).

(b) The Utah NetCare Basic Health Care Plan benefits may exclude state mandates as permitted by Section 31A-22-618.5.

(c) (i) Except as provided in Subsection (5)(c)(ii), the Utah NetCare Basic Health Care Plan's lifetime maximum benefit per person may not be less than $1 million.

(ii) The lifetime maximum benefit per person may be not less than $250,000, if the Utah NetCare Basic Health Care Plan is an election for alternative COBRA coverage under Section 31A-22-724.

(d) The Utah NetCare Basic Health Care Plan's annual maximum benefit per person may not be less than $250,000.

(e) The Utah NetCare Basic Health Care Plan shall have the following deductibles:

(i) for the low deductible plans:

(A) $2,000 for an individual plan; and

(B) $6,000 for a family plan;

(ii) for the high deductible plans:

(A) $4,000 for an individual plan; and

(B) $12,000 for a family plan.

(f) The Utah NetCare Basic Health Care Plan shall have the following out-of-pocket maximum costs, including deductibles, co-pays and co-insurance:

(i) for the low deductible plans:

(A) $5,000 for an individual plan; and

(B) $15,000 for a family plan; and

(ii) for the high deductible plan:

(A) $10,000 for an individual plan; and

(B) $30,000 for a family plan.

(g) The Utah NetCare Basic Health Care Plan shall provide the following preventive care benefits before applying any deductible requirements:

(i) all well child exams and immunizations up to age 5, with no annual maximum;

(ii) preventive care up to a $500 annual maximum;

(iii) primary care, specialist and urgent care up to a $300 annual maximum; and

(iv) supplemental accident coverage up to a $500 annual maximum.

(h) The Utah Netcare Basic Health Care Plan shall include the following co-payments for each exam:

(i) $15 for preventative care and well child exams;

(ii) $25 for primary care; and

(iii) $50 for urgent care and specialist care.

(i) The Utah NetCare Basic Health Care Plan shall include a $200 co-payment for emergency room visits after applying the deductible.

(j) The Utah NetCare Basic Health Care Plan shall require no less than a 30% co-insurance after deductible for hospital services, maternity, laboratory work, x-rays, outpatient surgery services, injectable medications, durable medical equipment, ambulance services, in-patient mental health services, and out-patient mental health services.

(k) The Utah NetCare Basic Health Care Plan:

(i) shall have the following cost-sharing features for prescription drugs:

(A) a $15 co-pay for generic drugs; and

(B) 50% co-insurance for name brand drugs; and

(ii) may include formularies and preferred drug lists.

Section 4. Section **31A-22-614.5** is amended to read:

**31A-22-614.5. Uniform claims processing -- Electronic exchange of health information.**

(1) Beginning July 1, 1993, all insurers offering health insurance shall use a uniform claim form and uniform billing and claim codes.

(2) The uniform claim forms and billing codes shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act. The commissioner shall consult with the director of the Division of Health Care Financing, the National Uniform Claim Form Task Force, and the National Uniform Billing Committee when adopting the uniform claims and billing codes.

(3) (a) (i) Beginning July 1, 1995, all insurers shall offer compatible systems of electronic billing approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(ii) The systems approved by the commissioner may include monitoring and disseminating information concerning eligibility and coverage of individuals.

(iii) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health for the implementation of the standards for the electronic exchange of clinical health information under Section 26-1-37. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health is given the opportunity to comment on proposed rules.

(b) The commissioner shall regulate any fees charged by insurers to the providers for:

(i) uniform claim forms;

(ii) electronic billing; or

(iii) the electronic exchange of clinical health information permitted by Section 26-1-37.

(4) Beginning July 1, 2009, the commissioner shall adopt administrative rules necessary to establish uniform electronic standards for the implementation of:

(a) Section 31A-22-635, Uniform health insurance applications; and

(b) the Internet portal created in Subsection 63M-1-2504(2), which shall:

(i) organize and present available health insurance options for individuals and groups, including:

(A) group plans;

(B) individual plans; and

(C) public programs;

(ii) create, display, and compare information required by Section 31A-22-613.5; and

(iii) register the receipt and transmission of premium contributions from multiple sources for plans offered under Chapter 30, Part 2, Defined Contribution Arrangements.

Section 5. Section **31A-22-618.5** is enacted to read:

**31A-22-618.5. Health plan offerings.**

(1) The purpose of this section is to increase the range of health benefit plans available in the market.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may if the provisions of Subsection (7 ) are met, offer to a potential purchaser a health benefit plan or limited health benefit plan that:

(i) is not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

(C) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(D) unless required by federal law, mandated coverage required by the following sections and related administrative rules:

(I) Section 31A-22-610.1 Adoption indemnity benefits;

(II) Section 31A-22-623 Inborn metabolic errors;

(III) Section 31A-22-624 Primary care physicians;

(IV) Section 31A-22-626 Coverage of diabetes;

(V) Section 31A-22-628 Standing referral to a specialist; or

(VI) coverage mandates enacted by the state after January 1, 2009; and

(ii) provides coverage for an emergency medical condition as required by Section 31A-22-627 as follows:

(A) within the organization's service area, covered services shall include health care services from non-affiliated providers only when delay in receiving care from an affiliated provider could reasonably be expected to place the enrollee's health in serious jeopardy; and

(B) outside the organization's service area, covered services shall include medically necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan and is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to a potential purchaser at least one health benefit plan that is subject to Sections 31A-22-617 and 31A-22-618; and

(b) may, if the provisions of Subsection (7 ) are met, offer to potential purchasers a health benefit plan that:

(i) is not subject to one or more of the following:

(A) Subsection 31A-22-617(2);

(B) Subsection 31A-22-617(7);

(C) notwithstanding Subsection 31A-22-617(9), Section 31A-22-618; or

(D) unless required by federal law, mandated coverage under the following:

(I) Section 31A-22-610.1 Adoption indemnity benefits;

(II) Section 31A-22-623 Inborn metabolic errors;

(III) Section 31A-22-624 Primary care physicians;

(IV) Section 31A-22-626 Coverage of diabetes;

(V) Section 31A-22-628 Standing referral to a specialist; or

(VI) coverage mandates enacted by the state after January 1, 2009; and

(ii) (A) is subject to Section 31A-8-501; and

(B) provides coverage of emergency care services as required by Section 31A-22-627 by providing coverage in accordance with Subsection 31A-22-617(2).

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5) (a) Any difference in price between a health benefit plan offered under Subsection (2)(a) and one offered under Subsection (2)(b):

(i) shall be based on actuarial differences in costs between the plans; and

(ii) is subject to Subsection 31A-30-106(1)(f)(ii)(B).

(b) Any difference in price between a health benefit plan offered under Subsections (3)(a) and (b):

(i) shall be based on actuarial differences in costs between the plans; and

(ii) is subject to Subsection 31A-30-106(1)(f)(ii)(B).

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

(7) (a) An insurer may offer a health benefit plan that is free of state mandates, in accordance with this section, only if the mandate-free product is offered:

(i) through the Internet portal created by Section 63M-1-2504; and

(ii) through a defined contribution arrangement created by Chapter 30, Part 2, Defined Contribution Arrangements.

(b) If an insurer meets the requirements of Subsection (7)(a), the insurer may also offer the mandate free product:

(i) by a method other than the Internet portal; and

(ii) in a defined benefit market.

Section 6. Section **31A-22-633** is amended to read:

**31A-22-633. Exemptions from standards.**

[~~Notwithstanding the provisions of Title 31A, Insurance Code, any~~]

(1) An accident and health insurer or health maintenance organization may offer a choice of coverage that is less or different than [~~is otherwise required by applicable state law if.~~] the Basic Health Care Plan or the Utah NetCare Basic Health Care Plan required by Section 31A-22-613.5 if:

[~~(1)~~] (a) the Department of Health offers a choice of coverage as part of a Medicaid waiver under Title 26, Chapter 18, Medical Assistance Act, which includes:

[~~(a)~~] (i) less or different coverage than the basic coverage;

[~~(b)~~] (ii) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or

[~~(c)~~] (iii) less or different coverage than required by Subsection 31A-22-605(4)(b); and

[~~(2)~~] (b) the choice of coverage offered by the carrier:

[~~(a)~~] (i) is the same or similar coverage as the coverage offered by the Department of Health under Subsection (1);

[~~(b)~~] (ii) is offered to the same or similar population as the coverage offered by the Department of Health under Subsection (1); and

[~~(c)~~] (iii) contains an explanation for each insured of coverage exclusions and limitations[~~;~~].

(2) Notwithstanding Section 31A-22-613.5, and subject to Subsection (3), an insurer may offer to potential purchasers a health benefit plan that:

(a) is not subject to state mandates as provided in Section 31A-22-618.5;

(b) includes coverage that applies against a plan year deductible and out-of-pocket maximum for:

(i) in-patient hospital and emergency care;

(ii) out-patient hospital services;

(iii) physician office visits;

(iv) diagnostic services, x-rays and laboratory services; and

(v) prescription drugs;

(c) has an annual lifetime maximum not lower than the annual lifetime maximums established for the basic health care plan or Utah NetCare Basic Health Care Plan offered under Section 31A-22-613.5;

(d) (i) in accordance with Subsection (2)(d)(ii), covers generally accepted preventive care services allowed by federal law, including:

(A) immunizations;

(B) cancer screenings;

(C) well-child exams; and

(D) preventive care prescription medications, including generics medications for:

(I) diabetes control;

(II) asthma control; and

(III) blood pressure control; and

(ii) covers the preventive care required by Subsection (2)(d)(i):

(A) without applying a deductible; and

(B) with a co-payment:

(I) that does not exceed $15 per visit, service, or generic prescription; and

(II) that may exceed $15 per prescription for non-generic drugs;

(e) entitles enrollees to the same discounted price for covered benefits and covered services without regard to whether:

(i) the patient or insurer is responsible for payment for the service or benefit; or

(ii) the patient has exhausted the maximum benefit for the covered service under the plan;

(f) has annual deductible of not more than:

(i) $5,800 fo an individual; and

(ii) $7,500 for a family;

(g) has an annual out of pocket maximum cost that:

(i) includes in-network deductibles, co-payments and co-insurance; and

(ii) is no higher that the highest out-of-pocket amount allowed in a federally qualifies high deductible health plan; and

(h) has an actuarial equivalent of not more than 100% of the Utah NetCare Basic Health Care Plan high deductible option.

(3) An insurer who offers a health benefit plan under Subsection (2), shall:

(a) if the insurer offers any small employer health benefit plans subject to Chapter 30, Individual, Small employer, and Group Health Insurance Act, offer at least one product in a defined contribution arrangement through the Internet portal in accordance with Chapter 30, Part 2, Defined Contribution Arrangements;

(b) offer the health benefit plan through the Internet portal created under Section 63M-1-2504; and

(c) offer to a potential purchaser of a health benefit plan under Subsection (2), an optional stand-alone policy or rider for basic preventive dental services.

(4) This section does not limit the number of health benefit plans an insurer may offer in the state.

[~~(3) the~~] (5) The commissioner and the executive director of the Department of Health shall report to the Health and Human Services Interim Committee prior to November 15 of each year concerning:

(a) the number of lives covered under any policy offered under the provisions of this

section or under the Medicaid waiver described in [~~Subsection (1)~~] Subsections (1) and (2);

(b) the claims experienced under the policies or Medicaid programs described in [~~Subsection (3)(a)~~] Subsections (1) and (2);

(c) any cost shifting to the private sector for care not covered under the programs or policies described in [~~Subsection (3)(a)~~] Subsections (1) and (2); and

(d) efforts or agreements between the Department of Health, the commissioner, insurers regulated under this chapter, and health care providers regarding combining publicly funded coverage with private, employer-based coverage to increase benefits and health care coverage.

Section 7. Section **31A-22-722** is amended to read:

**31A-22-722. Utah mini-COBRA benefits for employer group coverage.**

(1) An insured has the right to extend the employee's coverage under the current employer's group policy for a period of [~~six~~] 12 months, except as provided in Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) any disability;

(i) leave of absence; or

(j) reduction of hours.

(2) (a) Notwithstanding the provisions of Subsection (1), an employee does not have the right to extend coverage under the current employer's group policy if the employee:

(i) failed to pay any required individual contribution;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performed an act or practice that constitutes fraud in connection with the coverage;

(iv) made an intentional misrepresentation of material fact under the terms of the

coverage;

(v) was terminated for gross misconduct;

(vi) has not been continuously covered under the current employer's group policy for a period of [~~six~~] three months immediately prior to the termination of the policy due to the events set forth in Subsection (1); [~~or~~]

(vii) is eligible for any extension of coverage required by federal law[~~.~~]; or

(viii) elected alternative coverage under Section 31A-22-724.

(b) The right to extend coverage under Subsection (1) applies to any spouse or dependent coverages, including a surviving spouse or dependents whose coverage under the policy terminates by reason of the death of the employee or member.

(3) (a) The employer shall provide written notification of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made to:

(i) the terminated insured;

(ii) if Section 31A-22-612 applies, the ex-spouse; or

(iii) if Subsection (2)(b) applies:

(A) to a surviving spouse; and

(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification shall be sent first class mail within 30 days after the termination date of the group coverage to:

(i) the terminated insured's home address as shown on the records of the employer;

(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;

(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and

(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in this Subsection (3) if:

(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and

(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5) The premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.

(6) Except as provided in this Subsection (6), the coverage extends without interruption for [~~six~~] 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and

(b) tenders the amount required to the employer or insurer.

(7) The insured's coverage may be terminated prior to [~~six~~] 12 months if the terminated insured:

(a) establishes residence outside of this state;

(b) moves out of the insurer's service area;

(c) fails to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(d) performs an act or practice that constitutes fraud in connection with the coverage;

(e) makes an intentional misrepresentation of material fact under the terms of the coverage;

(f) becomes eligible for similar coverage under another group policy; or

(g) employer's coverage is terminated, except as provided in Subsection (8).

(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, have the right to obtain extension of coverage under the replacement group policy:

(a) for the balance of the period the terminated insured would have extended coverage under the replaced group policy; and

(b) if the terminated insured is otherwise eligible for extension of coverage.

(9) (a) Within 30 days of the insured's exhaustion of extension of coverage, the employer shall provide the terminated insured and the ex-spouse, or, in the case of the death of the insured, the surviving spouse, or guardian of any dependents, written notification of the

right to an individual conversion policy under Section 31A-22-723.

(b) The notification required by Subsection (9)(a):

(i) shall be sent first class mail to:

(A) the insured's last-known address as shown on the records of the employer;

(B) the address of the surviving spouse, if different from the insured's address, and if shown on the records of the employer;

(C) the guardian of any dependents last known address as shown on the records of the employer, if different from the address of the surviving spouse; and

(D) the address of the ex-spouse as shown on the records of the employer, if applicable; and

(ii) shall contain the name, address, and telephone number of the insurer that will provide the conversion coverage.

Section 8. Section **31A-22-723** is amended to read:

**31A-22-723. Group and blanket conversion coverage.**

(1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection (3), all policies of accident and health insurance offered on a group basis under this title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated is entitled to choose a converted individual policy of similar accident and health insurance.

(2) A person who has lost group coverage may elect conversion coverage with the insurer that provided prior group coverage if the person:

[~~(a) has been continuously covered for a period of six months by the group policy or the group's preceding policies immediately prior to termination;~~]

[~~(b)~~] (a) has exhausted either:

(i) Utah mini-COBRA coverage as required in Section 31A-22-722 [~~or~~];

(ii) alternative COBRA coverage under Section 31A-22-724; or

(iii) federal COBRA coverage;

[~~(c)~~] (b) has not acquired or is not covered under any other group coverage that covers all preexisting conditions, including maternity, if the coverage exists; and

[~~(d)~~] (c) resides in the insurer's service area.

(3) This section does not apply if the person's prior group coverage:

(a) is a stand alone policy that only provides one of the following:

(i) catastrophic benefits;

(ii) aggregate stop loss benefits;

(iii) specific stop loss benefits;

(iv) benefits for specific diseases;

(v) accidental injuries only;

(vi) dental; or

(vii) vision;

(b) is an income replacement policy;

(c) was terminated because the insured:

(i) failed to pay any required individual contribution;

(ii) performed an act or practice that constitutes fraud in connection with the coverage; or

(iii) made intentional misrepresentation of material fact under the terms of coverage; or

(d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or 31A-30-107(2)(a).

(4) (a) The employer shall provide written notification of the right to an individual conversion policy within 30 days of the insured's termination of coverage to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) in the case of the death of the insured:

(A) the surviving spouse; and

(B) the guardian of any dependents, if different from a surviving spouse.

(b) The notification required by Subsection (4)(a) shall:

(i) be sent by first class mail;

(ii) contain the name, address, and telephone number of the insurer that will provide the conversion coverage; and

(iii) be sent to the insured's last-known address as shown on the records of the employer of:

(A) the insured;

(B) the ex-spouse; and

(C) if the policy terminates by reason of the death of the insured to:

(I) the surviving spouse; and

(II) the guardian of any dependents, if different from a surviving spouse.

(5) (a) An insurer is not required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(b) Except as provided in Subsection (5)(c), if the conversion is made from a health benefit plan, the employee or member must be offered:

(i) at least the basic benefit plan through December 31, 2009; and

(ii) beginning January 1, 2010, at least the Utah NetCare Basic Health Care plan, as provided in Section 31A-22-613.5.

(c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy.

(6) Written application for the converted policy shall be made and the first premium paid to the insurer no later than 60 days after termination of the group accident and health insurance.

(7) The converted policy shall be issued without evidence of insurability.

(8) (a) The initial premium for the converted policy for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to age, class of risk of the person, and the type and amount of insurance provided.

(b) The initial premium for the first 12 months may not be raised based on pregnancy of a covered insured.

(c) The premium for converted policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode or premium payment is mutually agreed upon.

(9) The converted policy becomes effective at the time the insurance under the group policy terminates.

(10) (a) A newly issued converted policy covers the employee or the member and must also cover all dependents covered by the group policy at the date of termination of the group coverage.

(b) The only dependents that may be added after the policy has been issued are children

and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

(c) At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(11) (a) To the extent the group policy provided maternity benefits, the conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of a pregnancy that exists on the date of conversion if one of the following is pregnant on the date of the conversion:

(i) the insured;

(ii) a spouse of the insured; or

(iii) a dependent of the insured.

(b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs after the date of conversion.

(12) Except as provided in this Subsection (12), a converted policy is renewable with respect to all individuals or dependents at the option of the insured. An insured may be terminated from a converted policy for the following reasons:

(a) a dependent is no longer eligible under the policy;

(b) for a network plan, if the individual no longer lives, resides, or works in:

(i) the insured's service area; or

(ii) the area for which the covered carrier is authorized to do business;

(c) the individual fails to pay premiums or contributions in accordance with the terms of the converted policy, including any timeliness requirements;

(d) the individual performs an act or practice that constitutes fraud in connection with the coverage;

(e) the individual makes an intentional misrepresentation of material fact under the terms of the coverage; or

(f) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(13) Conditions pertaining to health may not be used as a basis for classification under this section.

Section 9. Section **31A-22-724** is enacted to read:

**31A-22-724. Offer of alternative coverage -- Utah NetCare Basic Health Care**

**Plan.**

(1) For purposes of this section, "alternative coverage" means a high deductible and low deductible Utah Netcare Basic Health Care Plan adopted in accordance with Section 31A-22-613.5.

(2) (a) Beginning January 1, 2010, and except as provided in Subsection (3), a person may elect alternative coverage under this section if the person:

(i) is eligible for continuation of employer group coverage under federal COBRA laws;

(ii) is eligible for continuation of employer group coverage under state mini-COBRA under Section 31A-22-722; or

(iii) is eligible for a conversion to an individual plan from:

(A) an employer's group coverage under Section 31A-22-723; or

(B) the exhaustion of benefits under:

(I) alternative coverage elected in place of federal COBRA; or

(II) state mini-COBRA under Section 31A-22-722.

(b) The right to extend coverage under Subsection (2)(a) applies to any spouse or dependent coverages, including a surviving spouse or dependents whose coverage under the policy terminates by reason of the death of the employee or member.

(3) If a person elects federal COBRA coverage, or state mini-COBRA coverage under Section 31A-22-722, the person is not eligible to elect alternative coverage under this section until the person is eligible to convert coverage to an individual policy under the provisions of Section 31A-22-723.

(4) (a) Within 30 days of the termination of the health benefit plan of an employer's employee, the employer shall provide written notification of the right to elect alternative coverage to:

(i) the terminated insured;

(ii) if Section 31A-22-612 applies, the ex-spouse; or

(iii) if Subsection (2)(b) applies:

(A) the surviving spouse; and

(B) the guardian of any dependents, if different from a surviving spouse.

(b) The notification required by Subsection (4)(a) shall:

(i) be sent by first class mail;

(ii) contain the name, address, and telephone number of the insurer that will provide the alternative coverage; and

(iii) be sent to the last-known address as shown on the records of the employer of:

(A) the insured;

(B) if Subsection 31A-22-612 applies, the ex-spouse; and

(C) if Subsection (2)(b) applies to:

(I) the surviving spouse; and

(II) the address of the guardian of any dependents, if different from a surviving spouse, if shown on the records of the employer.

(5) Written application for the alternative coverage shall be made and the first premium paid to the insurer no later than 60 days after:

(a) termination of the employee's health benefit plan if the election of alternative coverage is made in place of federal COBRA coverage or state mini-COBRA coverage; or

(b) exhaustion of federal COBRA coverage or state mini-COBRA coverage if alternative coverage is elected in accordance with Subsection (3).

(6) The alternative coverage shall be issued without evidence of insurability.

(7) If an individual elects alternative coverage in place of federal COBRA coverage or state mini-COBRA coverage under Section 31A-22-722, the following applies to the alternative coverage:

(a) Subsection 31A-22-722(4), except that the premium amount is established under Section 31A-22-613.5; and

(b) Subsections 31A-22-722(5), (6), (7) and (9).

(8) If an individual elects alternative coverage as a conversion policy, the provisions of Subsections 31A-22-723(8) through (13) apply to the alternative coverage.

(9) (a) An insurer subject to Sections 31A-22-722 through 31A-22-724 shall prior to September 1, 2009, file an alternative coverage policy with the department that complies with this Section and Section 31A-22-613.5.

(b) The department shall:

(i) approve the plans that comply with this section and Section 31A-22-613.5; and

(ii) by October 1, 2009, develop a model letter for employers to use to notify an employee of the employee's options for alternative coverage.

Section 10. Section **31A-23a-401** is amended to read:

**31A-23a-401. Disclosure of conflicting interests.**

(1) (a) Except as provided under Subsection (1)(b):

(i) a licensee under this chapter may not act in the same or any directly related transaction as:

(A) a producer for the insured or consultant; and

(B) producer for the insurer; and

(ii) a producer for the insured or consultant may not recommend or encourage the purchase of insurance from or through an insurer or other producer:

(A) of which the producer for the insured or consultant or producer for the insured's or consultant's spouse is an owner, executive, or employee; or

(B) to which the producer for the insured or consultant has the type of relation that a material benefit would accrue to the producer for the insured or consultant or spouse as a result of the purchase.

(b) Subsection (1)(a) does not apply if the following three conditions are met:

(i) Prior to performing the consulting services, the producer for the insured or consultant shall disclose to the client, prominently, in writing:

(A) the producer for the insured's or consultant's interest as a producer for the insurer, or the relationship to an insurer or other producer; and

(B) that as a result of those interests, the producer for the insured's or the consultant's recommendations should be given appropriate scrutiny.

(ii) The producer for the insured's or consultant's fee shall be agreed upon, in writing, after the disclosure required under Subsection (1)(b)(i), but before performing the requested services.

(iii) Any report resulting from requested services shall contain a copy of the disclosure made under Subsection (1)(b)(i).

(2) A licensee under this chapter may not act as to the same client as both a producer for the insurer and a producer for the insured without the client's prior written consent based on full disclosure.

(3) Whenever a person applies for insurance coverage through a producer for the insured, the producer for the insured shall disclose to the applicant, in writing, that the producer

for the insured is not the producer for the insurer or the potential insurer. This disclosure shall also inform the applicant that the applicant likely does not have the benefit of an insurer being financially responsible for the conduct of the producer for the insured.

(4) If a licensee is subject to both this section and Subsection 31A-23a-501(4), the licensee shall provide the disclosures required under each statute.

Section 11. Section **31A-23a-501** is amended to read:

**31A-23a-501. Licensee compensation.**

(1) As used in this section:

(a) "Commission compensation" includes funds paid to or credited for the benefit of a licensee from:

(i) commission amounts deducted from insurance premiums on insurance sold by or placed through the licensee; or

(ii) commission amounts received from an insurer or another licensee as a result of the sale or placement of insurance.

(b) (i) "Compensation from an insurer or third party" means fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration:

(A) whether or not payable pursuant to a written agreement; and

(B) received from:

(I) an insurer; or

(II) a third party to the transaction for the sale or placement of insurance.

(ii) "Compensation from an insurer or third party administrator" does not mean compensation from a customer that is:

(A) a fee or pass-through costs as provided in Subsection (1)(e); or

(B) a fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner.

(c) (i) "Customer" means:

(A) the person signing the application or submission for insurance; or

(B) the authorized representative of the insured actually negotiating the placement of insurance with the producer.

(ii) "Customer" does not mean a person who is:

(A) a participant or beneficiary of an employee benefit plan; or

(B) covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the producer or affiliate.

[~~(b)~~] (d) (i) "Noncommission compensation" includes all funds paid to or credited for the benefit of a licensee other than commission compensation.

(ii) "Noncommission compensation" does not include charges for pass-through costs incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

[~~(c)~~] (e) "Pass-through costs" include:

(i) costs for copying documents to be submitted to the insurer; and

(ii) bank costs for processing cash or credit card payments.

(2) A licensee may receive from an insured or from a person purchasing an insurance policy, noncommission compensation if the noncommission compensation is stated on a separate, written disclosure.

(a) The disclosure required by this Subsection (2) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(b) Noncommission compensation shall be:

(i) limited to actual or reasonable expenses incurred for services; and

(ii) uniformly applied to all insureds or prospective insureds in a class or classes of business or for a specific service or services.

(c) A copy of the signed disclosure required by this Subsection (2) must be maintained by any licensee who collects or receives the noncommission compensation or any portion [~~thereof~~] of the noncommission compensation.

(d) All accounting records relating to noncommission compensation shall be maintained by the person described in Subsection (2)(c) in a manner that facilitates an audit.

(3) (a) A licensee may receive noncommission compensation when acting as a producer for the insured in connection with the actual sale or placement of insurance if:

(i) the producer and the insured have agreed on the producer's noncommission

compensation; and

(ii) the producer has disclosed to the insured the existence and source of any other compensation that accrues to the producer as a result of the transaction.

(b) The disclosure required by this Subsection (3) shall:

(i) include the signature of the insured or prospective insured acknowledging the noncommission compensation;

(ii) clearly specify the amount or extent of the noncommission compensation and the existence and source of any other compensation; and

(iii) be provided to the insured or prospective insured before the performance of the service.

(c) The following additional noncommission compensation is authorized:

(i) compensation received by a producer of a compensated corporate surety who under procedures approved by a rule or order of the commissioner is paid by surety bond principal debtors for extra services;

(ii) compensation received by an insurance producer who is also licensed as a public adjuster under Section 31A-26-203, for services performed for an insured in connection with a claim adjustment, so long as the producer does not receive or is not promised compensation for aiding in the claim adjustment prior to the occurrence of the claim;

(iii) compensation received by a consultant as a consulting fee, provided the consultant complies with the requirements of Section 31A-23a-401; or

(iv) other compensation arrangements approved by the commissioner after a finding that they do not violate Section 31A-23a-401 and are not harmful to the public.

(4) (a) For purposes of this Subsection (4), "producer" includes:

(i) a producer;

(ii) an affiliate of a producer; or

(iii) a consultant.

(b) Beginning January 1, 2010, in addition to any other disclosures required by this section, a producer may not accept or receive any compensation from an insurer or third party administrator for that placement of health care insurance unless prior to the customer's purchase or renewal of health care insurance the producer:

(i) obtains the customer's signed acknowledgment that the compensation from an

insurer or third party administrator may be received by the producer; and

(ii) provides a description of the possible type and amount of compensation from an insurer or third party administrator for that placement.

(c) A copy of the signed acknowledgment required by Subsection (4)(b)(i) must be maintained by the licensee who collects or receives any part of the compensation from an insurer or third party administrator in a manner that facilitates an audit.

(d) This Subsection (4) does not apply to:

(i) a person licensed as a producer who acts only as an intermediary between an insurer and the customer's producer, including a managing general agent; or

(ii) the placement of insurance in a secondary or residual market.

[~~(4)~~] (5) This section does not alter the right of any licensee to recover from an insured the amount of any premium due for insurance effected by or through that licensee or to charge a reasonable rate of interest upon past-due accounts.

[~~(5)~~] (6) This section does not apply to bail bond producers or bail enforcement agents as defined in Section 31A-35-102.

Section 12. Section **31A-30-102** is amended to read:

**31A-30-102. Purpose statement.**

The purpose of this chapter is to:

(1) prevent abusive rating practices;

(2) require disclosure of rating practices to purchasers;

(3) establish rules regarding:

(a) a universal individual and small group application; and

(b) renewability of coverage;

(4) improve the overall fairness and efficiency of the individual and small group insurance market; [~~and~~]

(5) provide increased access for individuals and small employers to health insurance[~~.~~]; and

(6) provide small employers and individuals the opportunity to establish a defined contribution arrangement to purchase a health benefit plan.

Section 13. Section **31A-30-103** is amended to read:

**31A-30-103. Definitions.**

As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual approved by the commissioner that a covered carrier is in compliance with Section 31A-30-106, based upon the examination of the covered carrier, including review of the appropriate records and of the actuarial assumptions and methods used by the covered carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the covered carrier to covered insureds with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic coverage" means the coverage provided in:

(a) the Basic Health Care Plan under Subsection 31A-22-613.5(2)[~~,~~] until December 31, 2009; and

(b) the Utah NetCare Basic Health Plan under Subsection 31A-22-613.5(2) beginning January 1, 2010.

(5) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under this title.

(6) (a) Except as provided in Subsection (6)(b), "case characteristics" means demographic or other objective characteristics of a covered insured that are considered by the carrier in determining premium rates for the covered insured.

(b) "Case characteristics" do not include:

(i) duration of coverage since the policy was issued;

(ii) claim experience; and

(iii) health status.

(7) "Class of business" means all or a separate grouping of covered insureds established under Section 31A-30-105.

(8) "Conversion policy" means a policy providing coverage under the conversion provisions required in Chapter 22, Part 7, Group Accident and Health Insurance.

(9) "Covered carrier" means any individual carrier or small employer carrier subject to this chapter.

(10) "Covered individual" means any individual who is covered under a health benefit plan subject to this chapter.

(11) "Covered insureds" means small employers and individuals who are issued a health benefit plan that is subject to this chapter.

(12) "Dependent" means an individual to the extent that the individual is defined to be a dependent by:

(a) the health benefit plan covering the covered individual; and

(b) Chapter 22, Part 6, Accident and Health Insurance.

(13) "Established geographic service area" means a geographical area approved by the commissioner within which the carrier is authorized to provide coverage.

(14) "Index rate" means, for each class of business as to a rating period for covered insureds with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Individual carrier" means a carrier that provides coverage on an individual basis through a health benefit plan regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar groups; or

(b) the policy or contract is situated out-of-state.

(16) "Individual conversion policy" means a conversion policy issued to:

(a) an individual; or

(b) an individual with a family.

(17) "Individual coverage count" means the number of natural persons covered under a carrier's health benefit products that are individual policies.

(18) "Individual enrollment cap" means the percentage set by the commissioner in accordance with Section 31A-30-110.

(19) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or that could have been charged or offered, by the carrier to covered insureds with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(20) "Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is not a plan document, the plan year is:

(a) the deductible or limit year used under the plan;

(b) if the plan does not impose a deductible or limit on a yearly basis, the policy year;

(c) if the plan does not impose a deductible or limit on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer's taxable year; or

(d) in any case not described in Subsections (20)(a) through (c), the calendar year.

(21) "Preexisting condition" is as defined in Section 31A-1-301.

(22) "Premium" means all monies paid by covered insureds and covered individuals as a condition of receiving coverage from a covered carrier, including any fees or other contributions associated with the health benefit plan.

(23) (a) "Rating period" means the calendar period for which premium rates established by a covered carrier are assumed to be in effect, as determined by the carrier.

(b) A covered carrier may not have:

(i) more than one rating period in any calendar month; and

(ii) no more than 12 rating periods in any calendar year.

(24) "Resident" means an individual who has resided in this state for at least 12 consecutive months immediately preceding the date of application.

(25) "Short-term limited duration insurance" means a health benefit product that:

(a) is not renewable; and

(b) has an expiration date specified in the contract that is less than 364 days after the

date the plan became effective.

(26) "Small employer carrier" means a carrier that provides health benefit plans covering eligible employees of one or more small employers in this state, regardless of whether:

(a) coverage is offered through:

(i) an association;

(ii) a trust;

(iii) a discretionary group; or

(iv) other similar grouping; or

(b) the policy or contract is situated out-of-state.

(27) "Uninsurable" means an individual who:

(a) is eligible for the Comprehensive Health Insurance Pool coverage under the underwriting criteria established in Subsection 31A-29-111(5); or

(b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and

(ii) has a condition of health that does not meet consistently applied underwriting criteria as established by the commissioner in accordance with Subsections 31A-30-106(1)(i) and (j) for which coverage the applicant is applying.

(28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for purposes of this formula:

(a) "CI" means the carrier's individual coverage count as of December 31 of the preceding year; and

(b) "UC" means the number of uninsurable individuals who were issued an individual policy on or after July 1, 1997.

Section 14. Section **31A-30-107** is amended to read:

**31A-30-107. Renewal -- Limitations -- Exclusions -- Discontinuance and nonrenewal.**

(1) Except as otherwise provided in this section, a small employer health benefit plan is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A small employer health benefit plan may be discontinued or nonrenewed:

(a) for a network plan, if:

(i) there is no longer any enrollee under the group health plan who lives, resides, or works in:

(A) the service area of the covered carrier; or

(B) the area for which the covered carrier is authorized to do business; and

(ii) in the case of the small employer market, the small employer carrier applies the same criteria the small employer carrier would apply in denying enrollment in the plan under Subsection 31A-30-108(7); or

(b) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(3) A small employer health benefit plan may be discontinued if:

(a) a condition described in Subsection (2) exists;

(b) except as prohibited by Subsection 31A-30-202(3), the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the covered carrier:

(i) elects to discontinue offering a particular small employer health benefit product delivered or issued for delivery in this state; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 90 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner; and

(II) at least three working days prior to the date the notice is sent to the affected plan sponsors, employees, and dependents of the plan sponsors or employees;

(C) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other small employer health benefit products currently being offered by the small employer carrier in the market; and

(D) in exercising the option to discontinue that product and in offering the option of coverage in this section, acts uniformly without regard to:

(I) the claims experience of a plan sponsor;

(II) any health status-related factor relating to any covered participant or beneficiary; or

(III) any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the covered carrier:

(i) elects to discontinue all of the covered carrier's small employer health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; and

(ii) (A) provides notice of the discontinuation in writing:

(I) to each plan sponsor, employee, or dependent of a plan sponsor or an employee; and

(II) at least 180 days before the date the coverage will be discontinued;

(B) provides notice of the discontinuation in writing:

(I) to the commissioner in each state in which an affected insured individual is known to reside; and

(II) at least 30 working days prior to the date the notice is sent to the affected plan sponsors, employees, and the dependents of the plan sponsors or employees;

(C) discontinues and nonrenews all plans issued or delivered for issuance in the market; and

(D) provides a plan of orderly withdrawal as required by Section 31A-4-115.

(4) A small employer health benefit plan may be discontinued or nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's employer contribution requirements.

(5) A small employer health benefit plan may be nonrenewed:

(a) if a condition described in Subsection (2) exists; or

(b) for noncompliance with the insurer's minimum participation requirements.

(6) (a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice that constitutes fraud in connection with the coverage; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee that is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the date of discontinuance; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage is discontinued under Subsection (6)(a), the covered carrier shall notify the eligible employee of the right to reenroll when coverage is discontinued.

(d) An eligible employee may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the small employer health benefit plan is made available by a covered carrier in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) A covered carrier may modify a small employer health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 15. Section **31A-30-112** is amended to read:

**31A-30-112. Employee participation levels.**

(1) (a) Except as provided in Subsection (2) of this section and Subsection 31A-30-202(3), a requirement used by a covered carrier in determining whether to provide

coverage to a small employer, including a requirement for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the covered carrier.

(b) In addition to applying Subsection 31A-1-301(121), a covered carrier may require that a small employer have a minimum of two eligible employees to meet participation requirements.

(2) A covered carrier may not increase a requirement for minimum employee participation or a requirement for minimum employer contribution applicable to a small employer at any time after the small employer is accepted for coverage.

Section 16. Section **31A-30-201** is enacted to read:

**Part 2. Defined Contribution Arrangements**

**31A-30-201. Title.**

This part is known as "Defined Contribution Arrangements".

Section 17. Section **31A-30-202** is enacted to read:

**31A-30-202. Definitions.**

For purposes of this part:

(1) "Section 125 plan" means a plan that qualifies under Section 125 of the Internal Revenue Code which permits an employee to contribute pre-tax dollars to a health benefit plan; and

(2) "Self-funded plan" means a health benefit plan that:

(a) is not subject to regulation by this state or any other state;

(b) is paid in whole or in part from:

(i) the employer's assets; or

(ii) from a funded welfare benefit plan; and

(c) except for reinsurance or stop-loss coverage, does not shift any risk or liability for benefit payments to an insurer or other carrier.

Section 18. Section **31A-30-203** is enacted to read:

**31A-30-203. Insurer Requirements -- Employer responsibilities -- Self Funded Plans.**

(1) An employer who chooses to establish a defined contribution arrangement to

provide a health benefit plan for its employees shall:

(a) establish a Section 125 plan;

(b) offer its employees a choice of one or more health benefit plans available through the Internet portal created under Section 63M-1-2504;

(c) automatically enroll an employee in a health benefit plan that is available through the Internet portal and, selected by the employer, if the employee does not:

(i) select a different health benefit plan available through the Internet portal;

(ii) provide proof of coverage from another health benefit plan; or

(iii) specifically decline coverage through a health benefit plan available through the Internet portal.

(2) An insurer who offers a health benefit plan for which an employer has established a defined contribution arrangement under the provisions of this part:

(a) shall not:

(i) establish a small employer minimum contribution level for the health benefit premium under Section 31A-30-112, or any other law; or

(ii) discontinue or non-renew a policy under Subsection 31A-30-107(4) for failure to maintain a minimum employer contribution level;

(b) shall accept premium payments for an enrollee from multiple sources, including:

(i) government assistance programs;

(ii) contributions from a Sec. 125 plan established by another employer of the enrollee; and

(iii) contributions from a Sec. 125 plan established by an employer of a spouse or dependent of the enrollee; and

(c) may require, as a condition of coverage, a minimum participation level for eligible employees of an employer.

(3) A self-funded benefit plan or a large group health benefit plan may elect to participate in the defined contribution arrangements under this part and has the same rights, responsibilities, and obligations as other participating insurers.

Section 19. Section **31A-30-204** is enacted to read:

**31A-30-204. Rating restrictions for defined contribution arrangements -- Risk adjuster mechanism.**

(1) Notwithstanding the provisions of Sections 31A-30-105 and 31A-30-106, an insurer who offers a health benefit plan in a defined contribution arrangement may base premium rates only on:

(a) age;

(b) geography; and

(c) family composition.

(2) An insurer who offers a health benefit plan available through the Internet portal shall participate in the risk adjuster mechanism created by Chapter 42. Utah Health Re-Insurance Pool.

Section 20. Section **31A-42-101** is enacted to read:

**CHAPTER 42. UTAH HEALTH RE-INSURANCE POOL**

**Part 1. General Provisions**

**31A-42-101. Title.**

This chapter is known as the "Utah Health Re- Insurance Pool."

Section 21. Section **31A-42-102** is enacted to read:

**31A-42-102. Definitions.**

As used in this chapter:

(1) "Board" means the board of directors of the Utah Health Re-Insurance Pool created in part 2, Creation of Pool.

(2) "COBRA"means:

(a) the Consolidated Omnibus Budget Reconciliation Act of 1985; and

(b) state mini-COBRA under Section 31A-22-722.

(3) "Pool" means the Utah Health Re-Insurance Pool created by this act.

(4) "Pool fund" means the Utah Health Re-insurance Pool Enterprise Fund created in Section 31A-42-211.

(5) "Self funded health benefit plan" means a health benefit plan that:

(a) is not subject to regulation by this state or any other state;

(b) is paid in whole or in part by:

(i) the employer from the employer's assets; or

(ii) from a funded welfare benefit plan; and

(c) except for re-insurance or stop-loss coverage, does not shift any risk or liability for

benefit payments to an insurer or other carrier.

Section 22. Section **31A-42-103** is enacted to read:

**31A-42-103. Applicability and scope.**

(1) Except as provided in Subsection (2), this chapter applies to a carrier as defined in Section 31A-30-103 who offers a health benefit plan that provides coverage to:

(a) (i) a small employer; or

(ii) a large employer health benefit plan; and

(b) regardless of whether the contract is issued to:

(i) an association;

(ii) a trust;

(iii) a discretionary group;

(iv) another similar grouping; or

(v) the situs of delivery of the policy or contract.

(2) This chapter does not apply to:

(a) individual policies;

(b) short term limited duration health insurance; or

(c) federally funded or partially funded programs.

Section 23. Section **31A-42-201** is enacted to read:

**Part 2. Creation of Pool**

**31A-42-201. Creation of Utah Health Re-Insurance Pool -- Board of directors -- Appointment -- Terms -- Quorum -- Plan preparation.**

(1) There is created the "Utah Health Re-Insurance Pool", a nonprofit entity within the Insurance Department.

(2) The pool shall be under the direction of a board of directors composed of 12 members.

(a) The governor shall appoint eleven of the directors from carriers and insurance arrangements in the state with the consent of the Senate as follows:

(i) there shall be no more than two members of the board who represent any one carrier or insurance arrangement; and

(ii) the members selected shall be from:

(A) the small group market;

(B) the large group market;

(C) preferred provider group plans; and

(D) health maintenance organizations.

(b) The board shall also include the commissioner or the commissioner's designee.

(3) (a) Except as required by Subsection (3)(b), as terms of current board members expire, the governor shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (3)(a), the governor shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(4) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term in the same manner as the original appointment was made.

(5) (a) (i) Members who are not government employees shall receive no compensation or benefits for the member's services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107 from the pool fund.

(ii) Members may decline to receive per diem and expenses for their service.

(b) (i) State government officer and employee members who do not receive salary, per diem, or expenses from their agency for their service may receive per diem and expenses incurred in the performance of their official duties from the pool at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(ii) A state government member who is a member because of their state government position may not receive per diem or expenses for their service.

(iii) State government officer and employee members may decline to receive per diem and expenses for their service.

(6) The board shall elect annually a chair and vice chair from its membership.

(7) Six board members are a quorum for the transaction of business.

(8) The action of a majority of the members of the quorum is the action of the board.

Section 24. Section **31A-42-202** is enacted to read:

**31A-42-202. Contents of plan.**

The board shall submit a plan of operation for the pool to the commissioner. The plan shall:

(1) demonstrate that any and all assumptions of risk or liability by the pool shall be based on sound financial and actuarial principles reviewed and established in advance by the board and approved by the commissioner;

(2) establish procedures in compliance with Title 51, Chapter 7, State Money Management Act, and accounting policies and procedures established by the Division of Finance, for handling and accounting of assets and money of the pool;

(3) establish regular times and places for meetings of the board;

(4) establish procedures for keeping records of all financial transactions and for sending annual fiscal reports to the commissioner;

(5) contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

(6) establish procedures to pay claims under the pool;

(7) establish procedures in compliance with Title 63A, Utah Administrative Services Code, to pay for administrative expenses incurred;

(8) establish the different types and kinds of risk that can be ceded to the pool by participating carriers;

(9) for each type of kind of risk that may be ceded to the pool, establish the share of risk to be pooled and the terms for apportioning claims associated with the risk between the ceding carrier and the pool; and

(10) establish the methodology for calculating and apportioning among participating carriers any assessments to cover losses incurred in the operation of the pool and the schedule for the assessments.

Section 25. Section **31A-42-203** is enacted to read:

**31A-42-203. Powers of board.**

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the board shall have the specific authority to:

(a) enter into contracts to carry out the provisions and purposes of this chapter,

including, with the approval of the commissioner, contracts with:

(i) similar pools of other states for the joint performance of common administrative functions; or

(ii) persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking legal action necessary to:

(i) avoid the payment of improper claims against the pool or the coverage provided through the pool; and

(ii) recover any assessments for, on behalf of, or against members of the pool;

(c) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the pool;

(d) define the type of health benefit plans for which re-insurance will be provided, in accordance with this chapter;

(e) issue re-insurance policies in accordance with this chapter;

(f) establish rules and conditions pertaining to the reinsurance of a participating carrier's risks by the pool;

(g) assess participating carriers in accordance with Section 31A-42-208, and make interim assessments as may be reasonable and necessary for organizational and interim operating expenses;

(h) retain an executive director and appropriate legal, actuarial, and other personnel as necessary to provide technical assistance in the operations of the pool;

(i) cause the pool to have an annual audit of its operations by the state auditor;

(j) provide for and employ cost containment measures and requirements for the purpose of making the pool more cost-effective;

(k) establish annual limits on benefits payable under the pool to or on behalf of any participating carrier;

(l) exclude from coverage under the pool specific benefits, medical conditions, and procedures for the purpose of protecting the financial viability of the pool;

(m) administer the pool fund; and

(n) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this chapter.

(2) (a) The board shall prepare and submit an annual report to the department for inclusion in the department's annual market report, which shall include:

(i) the net premiums anticipated;

(ii) actuarial projections of payments required of the pool;

(iii) the expenses of administration;

(iv) any assessments imposed under Section 31A-42-208; and

(v) the anticipated reserves or losses of the pool.

(b) The budget for operation of the pool is subject to the approval of the board.

(c) The administrative budget of the board and the commissioner under this chapter shall comply with the requirements of Title 63J, Chapter 1, Budgetary Procedures Act, and is subject to review and approval by the Legislature.

Section 26. Section **31A-42-204** is enacted to read:

**31A-42-204. Powers of commissioner.**

(1) The commissioner shall, after notice and hearing, approve the plan of operation if the commissioner determines that the plan:

(a) will assure the fair, reasonable, and equitable administration of the pool; and

(b) provides for the sharing of pool gains and losses on an equitable and proportionate basis.

(2) The plan shall be effective upon the adoption of administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) If the board fails to submit a proposed plan of operation by January 1, 2010, or any time thereafter fails to submit proposed amendments to the plan of operation within a reasonable time after requested by the commissioner, the commissioner shall, after notice and hearing, adopt such rules as necessary to effectuate the provisions of this chapter.

(4) Rules promulgated by the commissioner shall continue in force until modified by the commissioner or until superseded by a subsequent plan of operation submitted by the board and approved by the commissioner.

(5) The commissioner may designate an executive secretary from the department to provide administrative assistance to the board in carrying out its responsibilities.

Section 27. Section **31A-42-205** is enacted to read:

**31A-42-205. Examination -- Financial report.**

(1) The pool is subject to examination by the commissioner.

(2) By December 1 of each year, the board shall submit to the commissioner an audited financial report for the preceding fiscal year in a form approved by the commissioner.

Section 28. Section **31A-42-206** is enacted to read:

**31A-42-206. Pool administrator -- Selection -- Powers.**

(1) The board shall select a pool administrator in accordance with Title 63G, Chapter 6, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) proven ability to handle accident and health re-insurance;

(b) efficiency of claim paying procedures;

(c) underwriting;

(d) an estimate of total charges for administering the pool; and

(e) ability to administer the pool in a cost-efficient manner.

(2) (a) The pool administrator shall serve for a period of five years, with two one-year extension options, subject to the terms, conditions, and limitations of the contract between the board and the administrator.

(b) At least one year prior to the expiration of the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator.

(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of the period of service under Subsection (2)(a).

(3) The pool administrator is responsible for all operational functions of the pool and shall:

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by statute to be confidential;

(b) perform all eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from reinsuring carriers;

(d) perform all necessary functions to ensure timely payment of benefits to participating insurers, including:

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

(ii) evaluating the eligibility of each claim for payment by the pool;

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which shall be determined by the board;

(f) (i) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year; and (ii) submit a report of the information required in this Subsection (f) to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Section 29. Section **31A-42-207** is enacted to read:

**31A-42-207. Eligibility for pool membership and ceding risk.**

(1) (a) Every carrier licensed to offer a health benefit plan in the state shall participate in the pool as a condition of its authority to transact business in the state if the carrier offers one or more of the following:

(i) a group health plan as defined in Section 31A-1-301;

(ii) continuation coverage under COBRA;

(iii) health insurance to a large employer as defined in Section 31-1-301;

(iv) a small employer plan under Chapter 30, Individual, Small Employer and Group Health Insurance Act; or

(v) a health benefit plan offered through the Internet portal, in a defined contribution arrangement under Chapter 30, Part 2, Defined Contribution Arrangements.

(b) Subsection (1)(a) does not apply to health benefit plans offered to an individual.

(2) Notwithstanding the provisions of Subsection 31A-30-104(4)(c), a carrier may reinsure with the pool:

(a) if the carrier offers a product through the Internet portal, under a defined contribution arrangement;

(b) for the enrollees in the products offered through the Internet portal under a defined contribution arrangement; and

(c) if the carrier complies with the provisions of this section.

(3) (a) A self funded health benefit plan may elect to participate in the pool in accordance with this Subsection (3).

(b) A self funded plan that elects to participate in the pool:

(i) is a participating carrier for purposes of this act;

(ii) has the same rights, privileges, responsibilities, and obligations as other participating carriers; and

(iii) must contract with the plan administrator that for each of the three plan years immediately following the plan's withdrawal from the pool, the plan sponsor is subject to assessments by the pool under Section 31A-42-208 as if the plan were still a participating carrier in the pool.

(4) (a) The pool shall reinsure the level of coverage provided in the carrier's health benefit plan and shall adjust premiums and assessments for the reinsurance based on that level of coverage.

(b) A reinsuring carrier may reinsure:

(i) an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan; or

(ii) an eligible employee or dependent within a 60 day period following the commencement of the coverage with the employer.

(5) The pool may reimburse a reinsuring carrier with respect to a claim of a reinsured enrollee or dependent:

(a) if, in the aggregate, the amount of claims for an employee or a dependent in the plan year are $5,000 or higher; and

(b) if the reinsuring carrier maintains 20% of the risk of claims for the employee or dependent, up to a maximum of $55,000 in claims for the employee or dependent for the plan year.

(6) The board shall annually adjust the initial level of claims and the maximum limit to be retained by the reinsuring carrier to reflect increases in cost and utilization within the health benefit plans within the state.

(7) A participating carrier may terminate re-insurance with the pool for one or more of the reinsured employees or dependents on any anniversary date of the health benefit plan.

(8) A carrier who cedes risk to the pool shall apply all managed care and claims handling techniques, including utilization review, healthy behavior and wellness programs, individual case management, pharmacy provisions, and any other type of cost or quality control programs within a health benefit plan consistently among all enrollees of the health benefit plan, regardless of whether the enrollee is reinsured with the pool.

Section 30. Section **31A-42-208** is enacted to read:

**31A-42-208. Premiums -- Assessment for pool.**

(1) (a) Premiums for reinsurance by the pool shall be assessed annually by the board according to the plan adopted by the board.

(b) Premiums charged for reinsurance by the pool to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and is subject to federal limits on the amount of risk that can be ceded, may be modified by the board as necessary to comply with federal law.

(2) If premiums or other receipts received by the pool exceed the amount required for the operation of the pool, including actual losses and administrative expenses, the board shall direct that the excess be held in the pool fund, or used to offset future losses, including reserves for incurred but not reported claims.

(3) (a) A deficit shall be incurred by the pool when anticipated losses plus incurred but not reported claims expenses exceed anticipated income from earned premiums net of administrative expenses.

(b) (i) A deficit incurred or expected to be incurred, shall be recovered from assessments on participating carriers in accordance with this section and the plan of operation adopted by the board.

(ii) The assessment formula adopted by the board in its plan of operation shall apply to participating insurers as required by Subsection 31A-42-207(1), and shall be based on each participating carrier's share of the total premiums earned in the preceding calender year for the health benefit plans delivered or issued in the state.

(iii) Prior to March 1 of each year the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the pool in

the previous calender year.

(c) A participating carrier may petition the board for an abatement or deferment of all or part of an assessment. The board may abate or defer, in whole or in part, the assessment if, in the opinion of the board, payment of the assessment would endanger the ability of the participating carrier to fulfill its contractual obligations to pay covered claims. A participating carrier receiving a deferment shall remain liable to the pool for the deficiency.

(d) A participating carrier may appeal a decision of the board to the commissioner in accordance with Title 63G, Chapter 4, Administrative Procedures Act.

Section 31. Section **31A-42-209** is enacted to read:

**31A-42-209. Enterprise fund.**

(1) There is created an enterprise fund known as the Utah Health Re-Insurance Pool Enterprise Fund.

(2) The following funds shall be credited to the pool fund:

(a) appropriations from XXXXX;

(b) pool policy premium payments;

(c) assessments collected by the pool under Section 31A-42-208; and

(d) all interest and dividends earned on the pool fund's assets.

(3) All money received by the pool fund shall be deposited in compliance with Section 51-4-1 and shall be held by the state treasurer and invested in accordance with Title 51, Chapter 7, State Money Management Act.

(4) The pool fund shall comply with the accounting policies, procedures, and reporting requirements established by the Division of Finance.

(5) The pool fund shall comply with Title 63A, Utah Administrative Services Code.